Consent ID: VaxCore Clinic ID: School Name: Consent ID:	D H E C	Paren FOR CLINIC USE ONLY Partner ID:	t Consent for Seasonal I Partner Name:		VAX STATE VaxCare has partnered with your healthcare provider to provide immunizations. All bills for privately insured patients will come from either VaxCare or DHEC.
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to join or consolidate claims in arbitration by or against other individuals or entitles, or arbitrate any claims as a representative member of a class or in a private attorney general capacity. The foregoing arbitration provisions do not affect or apply to any disputes by or against DHEC or any action to which DHEC is a party, regardless of whether Vaxcare is also a party. DHEC does not consent to arbitration to resolve any claims, disputes, or actions. If consenting for another: I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration. *** PLEASE TURN THE PAGE OVER AND COMPLETE SCREENING QUESTIONS ON BACK BEFORE RETURNING TO SCHOOL *** Vaccination Details (Influenza: VO4.81) FOR CLINIC USE - BLACK INK ONLY FIRST DOSE	seasonal influenza vaccine at a school c	linic if my child is less than 9 years old i	and a second dose is recommended	d by the U.S. Centers for Disease Control and Pre	evention (CDC). In case of occupational exposure, I consent to my
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PATIENT/STUDENT'S ASSIGNED CLASSROOM TEACHER SIGNATURE

PATIENT/STUDENT'S ASSIGNED CLASSROOM TEACHER SIGNATU

Teacher: I hereby attest by signature above that the identity of the patient in question has been verified.

PATIENT/STUDENT'S ASSIGNED CLASSROOM TEACHER SIGNATURE

Influenza Vaccination: The following questions will help us determine if there is any reason we should not give your influenza vaccination. If a question is not clear, please ask your healthcare provider to explain it. PLEASE ANSWER ALL QUE				
1. Has your child ever had a <u>serious reaction</u> to eggs OR a serious reaction to a previous flu vaccine that caused any of the following: wheezing, trouble breathing, hives and itching all over the body, swelling in the mouth or throat, very low blood pressure or shock?				
2. Has your child ever had Guillain-Barre Syndrome (a rare type of temporary severe muscle weakness and paralysis)?	NO	YES		
If you answered YES to any of the questions above, your child cannot receive the 2015-2016 sea influenza vaccine at school. Please contact your primary healthcare provider about the flu vaccine at school.				
If you answered NO to the above questions, please complete the following additional questions:				
3. Has your child received any vaccine(s) within the past 30 days? If yes, list: Vaccine Name(s):	NO	YES		
4. Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), seizures (or other type of neurologic or neuromuscular disorder), or disease of the lungs, heart, kidney, liver, or blood (including anemia)?	NO	YES		
5. Is your child receiving aspirin therapy or aspirin-containing therapy?				
6. Does your child have a weak immune system? (For example, treatment for cancer or HIV/AIDS or taking medications such as steroids that may cause the immune system to be weak)				
7. Is your child pregnant? (Please discuss this question with your child for verification)				
8. Does your child have close contact with a person who needs care in a protected environment? (For example, someone who is in a bone marrow transplant unit.)	NO	YES		
9. If your child is 2-4 years of age , has your child had a wheezing episode in the past 12 months?	NO	YES		
10. If your child is under 9 years old , he/she may need 2 doses of flu vaccine. Please provide your child's date of birth <u>ONLY</u> if your child is under 9 years old.	<i>_</i>			
11. If your child is under 9 years old, has your child received at least two doses of influenza vaccine prior to July 1, 2015?	YES	UNSURE		
12. Please provide your email address (optional):				
Notes:				
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